COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH CONSENT TO PHOTOGRAPH/AUDIO RECORD

The undersigned client of responsible party	consents to and authorizes.	
		to
Name of Facility and/or	Program or Unit and/or Employee N	ame
photograph (which, as used in this Conse any other mechanical means audio record	nt, means motion picture, still photogra of recording and reproducing images	aphy in any form, videotapes, or)
The undersigned:		
agrees that photographs/au only by employees of the D educating and tra	dio recordings made as a resultepartment of Mental Health forsining relations and/or fund raising as	: research
except for these limitations:	:	
 holds the Department harm resulting from the activities understands this Consent resulting 	sation for use of the photograph less from and against any claim authorized by this Consent; emains valid unless the client or in writing, but that a new Conse ted above.	of injury or compensation legal representative
Signature of Client	**	Date
	_	
Signature of Responsible Party*	Relationship to Client	Date
Signature of Client		 Date
* Responsible Party – Guardian, Conservator ** A minor patient receiving services under his file in the clinical record.		red.
Signator [] was given or [] refused a copy	of this Consent on	by Initials
This confidential information is provided to you in accordance with Welfare and Institutions Code Section.5328. Duplication of this information for further disclosure is prohibited without the prior written consent of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required	Name:	MIS#
	Agency:	
after the stated purpose of the original request is fulfilled.	Los Angeles County Dena	artment of Mental Health